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BMJ EVIDENCE-BASED CLINICAL REVIEW:

Assessment and Management of Alcohol Use Disorders

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METHODS

This review will focus on practical aspects of the assessment and treatment of alcohol use disorders from the perspective of the non-specialist hospital doctor or general practitioner. It is structured around a series of clinical guidelines developed by the National Institute for Health and Care Excellence (NICE) [1-3]. Three separate expert groups considered public health, physical, and psychological and social issues around alcohol use. The guidance is summarised in the form of clinical pathways at http://pathways.nice.org.uk/pathways/alcohol-use-disorders

Introduction

Alcohol can impact on both the incidence and course of many health conditions, and nearly 6% of all global deaths in 2012 were estimated to be attributable to its consumption [4]. A quarter of the UK adult population drinks alcohol in a way that is potentially or actually harmful to their health [5]. Between 2002 and 2012 there was a doubling of the number of episodes where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis [6] . Despite the large numbers drinking alcohol at higher risk levels, a relatively low number access treatment [2]. Possible causes for this include missed opportunities to identify problems, limited access to specialist services, and underdeveloped care pathways. International studies have demonstrated that more than 20% of patients presenting to primary care are higher risk or dependent drinkers [7], yet the issue of alcohol is inadequately addressed.

How are Alcohol Use Disorders (AUDs) defined?

As the level of alcohol consumption goes up, so the risk of physical, psychological and social problems increases. Alcohol-related harm is a public health problem, and strategies that reduce average consumption across the whole population by even a small amount produce considerable health benefits. Increasing the cost of alcohol has been consistently associated with reduction in alcohol-related harm [8], and a minimum cost for a unit of alcohol has been under consideration in the UK [9].

Alcoholic drinks have different strengths, and so alcohol is not measured by number of drinks but by number of ‘units’. In the UK, one unit is 8 grams of alcohol (equivalent to 10 millilitres of pure

ethanol) but this value is defined differently elsewhere (see [10], page 10). **Box 1** shows how to calculate the number of units. The terminology used to define alcohol use disorders is currently evolving, with slightly different terms used by different organisations [11 12]. However, there is general agreement that there is no such thing as a 'safe level' of drinking, and that the risk of harm increases with either frequency of consumption and/or amount consumed on a drinking occasion [10]. In order to plan effective intervention strategies, the categories defined in table 1 are most commonly used. Figure 1 shows their prevalence in England.

[Insert Figure 1 here]

The term 'addiction' is not used in current classificatory systems, partly because it has pejorative connotations. The latest version of the Diagnostic and Statistical Manual (DSM-5) has removed the category of dependence, instead describing a spectrum of alcohol use disorders of different severity [13]. However, that the concept of alcohol dependence is important to describe individuals where the ability to control the frequency and extent of consumption has been completely eroded, while recognising that dependence may exist at different levels of severity [14 15].

How can we identify alcohol use disorders? Identification and Brief Advice (IBA)

As shown in figure 1, the majority of people with risky patterns of drinking are not dependent. A few minutes spent systematically identifying drinkers at increased risk of harm and delivering advice about moderating alcohol consumption has been shown to be an effective strategy in various settings [16 17], and the process of Identification and Brief Advice (IBA) should be offered as a first step in treatment [2]. NICE recommends that NHS professionals should carry out alcohol screening as part of routine practice [2], and all doctors should feel comfortable and confident in raising the topic of alcohol consumption in a consultation. However, the low level of detection and treatment suggests that generalists are not sufficiently proactive in screening potentially at-risk groups, including those

- with relevant physical conditions (e.g. hypertension and gastrointestinal/liver disorders);
- with mental health problems (e.g. anxiety or depression);
- who have been assaulted;
- at risk of self-harm;

- who regularly experience accidents or minor trauma;
- who regularly attend Genito-Urinary Medicine clinics or repeatedly seek emergency contraception.

The 'Alcohol Use Disorders Identification Test' (AUDIT, table 2) consists of 10 questions about drinking frequency and intensity, experience of alcohol-related problems, and signs of possible dependence [18],and is the 'gold standard' screening questionnaire for detecting drinkers at increasing or higher risk [2]. Furthermore, as **box 2** shows, the AUDIT score can guide the clinician as to the best intervention, including brief advice or a referral to specialist services. Scores should be revised downward when screening women, or people under 18 or over 65. Biochemical measures such as liver function tests are not normally used for screening, but may be helpful in assessing the severity and progress of an established alcohol-related problem, or as part of a secondary care assessment [19].

A guiding style that aims to build motivation and avoid confrontation is recommended, and motivational interviewing has shown considerable promise in this area. Although a review is beyond the scope of this article, useful materials can be found at www.motivationalinterviewing.org.

What treatments are available for alcohol dependence?

IBA is an important public health approach due to the numbers of people involved. However, even after gold-standard brief interventions in primary care, nearly two-thirds of individuals will still be drinking at an increasing or higher risk level [17]. At the 'dependent' end of the drinking spectrum, change is even more difficult to achieve. People with a moderate to severe level of alcohol dependence may benefit from more intensive help from mutual aid groups such as Alcoholic Anonymous and/or specialist treatment services [2]. Abstinence is the preferred goal for many such individuals, particularly for those whose organs have already been damaged through alcohol use, or for those who have previously attempted to cut down their drinking without success. In considering the correct level of treatment intensity it is important to consider risks, capacity to consent to treatment, the experience and outcome of previous episodes of treatment, motivation for change, and other existing problems including harm to others.

There are three interventions that may assist the generalist in altering the drinking trajectory:

1. Medically Assisted Withdrawal

The alcohol withdrawal syndrome develops when consumption is abruptly stopped or substantially reduced, and symptoms and signs appear within 6-8 hours. These include anxiety, tremor, sweating, nausea, tachycardia, and hypertension, usually peaking over 10-30 hours and subsiding within 2-3 days. Seizures may occur in the first 12-48 hours (but rarely after this), and delirium tremens is a serious condition that occurs 48-72 hours after cessation of drinking characterised by coarse tremor, agitation, fever, tachycardia, profound confusion, delusions, (characteristically frightening) auditory and visual hallucinations, and possibly hyperpyrexia, ketoacidosis and circulatory collapse.

Minor degrees of alcohol withdrawal are common, and can be managed with information, reassurance, and adequate fluid intake. However, the alcohol withdrawal syndrome is potentially life-threatening, and systematic reviews recommend long-acting benzodiazepines (chlordiazepoxide or diazepam) as the drug of choice for managing it and preventing serious complications such as seizures or delirium tremens [1 20]. The aim is to titrate the initial dose to the level of withdrawal symptoms and then slowly reduce the dose over 7-10 days using a standard 'fixed dose' protocol (see Table 3). Rating scales such as the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) can be used to measure the severity of the withdrawal symptoms and more accurately adjust the dose, but the use of such a 'symptom-triggered' regimen is only recommended if trained staff are available e.g. in an inpatient setting [3]. Prescribing in the community for alcohol dependent patients without adequate assessment and support is not recommended, as successful withdrawal is unlikely, and there are significant associated clinical risks. This is a common scenario facing GPs, and expeditious referral to specialist services for support from a specialist alcohol nurse during medicated withdrawal is advised.

Doses of benzodiazepines should be reduced for children and young people, older people, and people with impaired liver synthetic function e.g. reduced albumin or increased prothrombin time (where a benzodiazepine requiring less liver metabolism may be preferred e.g. oxazepam). Clinicians should be aware of complications of nutritional deficiency such as the Wernicke-Korsakoff Syndrome and how to prevent them [3]. Most episodes of medically assisted alcohol withdrawal can take place at home, but inpatient treatment should be considered if the person drinks more than 30 units of alcohol/day, a history of epilepsy, withdrawal-related seizures or delirium tremens, or co-morbid physical or mental health conditions [1].

2. Mutual Aid Facilitation

Treatment of alcohol withdrawal is not sufficient on its own, and should be viewed as the precursor to a longer-term treatment and rehabilitation process. Research consistently shows that people with

alcohol dependence who have stopped drinking are vulnerable to relapse, and may have unresolved problems that predispose them to this [21]. Mutual aid groups (such as Alcoholics Anonymous and SMART Recovery) are a source of ongoing support for people seeking recovery from alcohol dependence, and for partners, friends, children and other family members. Long-term cohort studies show that people who actively participate in mutual aid are more likely to sustain their recovery [22], and NICE recommends that treatment staff routinely provide information about mutual aid groups and facilitate access for those who want to attend [1].

Clinicians should be aware of the range of mutual aid groups available locally and how to access them. Level of clinician knowledge about AA groups has been positively correlated with levels of referral [23], and attending a meeting is an invaluable learning experience. RCT evidence suggests that proactive efforts to engage patients with mutual aid groups increase attendance, particularly introducing the patient to a group member in advance of a meeting [24]. A simple three stage process to guide this is available (see www.nta.nhs.uk/uploads/mutualaid-fama.pdf).

3. Relapse Prevention Medication

Interventions based on psychological or social processes of change are the mainstay of treatment for alcohol dependence (see [25] for a review). Although research suggests that such treatments lead to improved outcomes when compared to no treatment at all, the evidence favouring one type of psychological intervention over another is less clear. Other factors such as therapist characteristics and service variables are also important. There is wide variation in the uptake and implementation of psychological approaches in the UK [1 26], and most practice involves an eclectic approach that combines strategies from various psychological approaches that typically lasts 12 weeks. In the individual who has decided to become abstinent from alcohol, this treatment is enhanced by both mutual aid group attendance and the prescribing of relapse prevention medication. The following medications can all be prescribed in primary care, though they may all be initiated and monitored by a specialist.

Acamprosate and the opioid-antagonist naltrexone are both effective in increasing the time to first drink and to relapse in people with alcohol dependence who have achieved abstinence [1]. Acamprosate may also be neuroprotective, and is believed to act by altering the balance between excitatory and inhibitory neurotransmission [20]. Naltrexone appears to reduce cravings by reducing the reinforcing effect of alcohol consumption. Both should only be used in combination with an individual psychological intervention, started as soon as possible after withdrawal, and may be prescribed for 6 months or more depending on perceived benefit. Systematic reviews suggest a

number needed to treat to prevent return to any drinking of between 12 and 20 [27]. Disulfiram (*Antabuse*) works by interfering with the metabolism of alcohol, causing an accumulation of acetaldehyde in the body and so throbbing headache, facial flushing, palpitations, dyspnoea, tachycardia, nausea and vomiting within ten minutes of alcohol consumption. Its use as a deterrent is most suited to people who have abstinence as a goal, and who have someone to supervise consumption each day. Treatment should be started at least 24 hours after the last alcoholic drink, and disulfiram should be used with caution in pregnancy, liver disease, severe mental illness, stroke, heart disease or hypertension. Patients need to know about the symptoms caused by the interaction between alcohol and disulfiram, and the rare and unpredictable onset of hepatotoxicity which is unrelated to dose.

Nalmefene is an opioid antagonist that is indicated for the reduction of alcohol consumption in adults with alcohol dependence who have a high drinking risk level (more than 7.5 units/day in men and 5 units/day in women), but without physical withdrawal symptoms and who do not need immediate medically assisted withdrawal. It should be initiated only in patients who continue to have a high drinking risk level two weeks after initial assessment, and it should only be prescribed in conjunction with continuous psychosocial support focused on treatment adherence and reducing alcohol consumption. Such psychosocial support can be delivered in primary care, and this seems to be a cost-effective approach to addressing higher risk drinking [28_ENREF_28]. The recommended dose is one oral tablet on each day the person perceives a risk of drinking, ideally 1-2 hours before the anticipated time of drinking.

Competing Interests Statement

We have read and understood the BMJ Group policy on declaration of interests and declare the following interests:

Ed Day is a member of the Addictions Department at the Institute of Psychiatry, Psychology and Neuroscience, King's College London. The department is in receipt or has received grants from the MRC and the NIHR to research both pharmacological and psychosocial treatments for alcohol use disorders. He is currently a co-investigator on NIHR HTA grant (13/86/03) to investigate the effectiveness of adjunctive Medication Management and Contingency Management in enhancing adherence to medications for relapse prevention in alcohol dependence. He is a trustee of the charities Action on Addiction and Changes UK.

Alex Copello is an honorary member of the School of Psychology at the University of Birmingham, and his department is in receipt or has received grants from the MRC and the NIHR to research psychosocial treatments for alcohol use disorders. He is Chief Investigator on a randomised

controlled trial of family and social network intervention for young people who misuse alcohol and drugs (HTA grant 11/60/01) and Principal Investigator on a pilot study to assess the feasibility and impact of a motivational intervention on problem drug and alcohol use in adult mental health in-patient units (NIHR - PB-PG-1010-23138). He is an expert advisor to the charity Action on Addiction.

Martyn Hull is a member of SMMGP (Substance Misuse Management in General Practice) and has been funded via SMMGP by Lundbeck to complete and tutor on the SMMGP Advanced Certificate in the Community Management of Alcohol Disorders.

SUMMARY POINTS

- Alcohol use disorders exist across a spectrum, and public health measures to reduce the drinking of the whole population have considerable health benefits
- All front-line clinicians should be aware of the potential effects of alcohol consumption, and be able to screen for AUDs using AUDIT
- Brief interventions are quick and easy to deliver and have a potentially large impact on reducing hazardous and harmful drinking
- Benzodiazepines are the medication of choice for medically assisted alcohol withdrawal
- Relapse to drinking is common in the first year after stopping drinking, but psychological treatments, mutual aid groups and relapse prevention medication increase the likelihood of remaining abstinent

TIPS FOR NON-SPECIALISTS

- Consider the far reaching effects of alcohol, not only to individual physical and mental health, but to family members and the community as a whole
- Screening for alcohol problems in all healthcare settings, and particularly in high risk populations
- Providing structured brief advice and feedback is an effective strategy in high risk drinkers
- Adopt a positive, motivational approach to managing AUDs
- Take a long-term, stepped care perspective, moving to more intensive interventions when a less intensive option hasn't worked
- Promote attendance at mutual aid groups such as Alcoholics Anonymous or SMART Recovery UK wherever possible

QUESTIONS FOR FUTURE RESEARCH

- What methods are effective for assessing and diagnosing the presence and severity of alcohol use disorders in children and young people?
- What are the most effective strategies for facilitating the delivering of alcohol identification and brief advice in routine clinical practice?
- Is an assertive community treatment model for moderate to severe alcohol dependence clinically and cost effective compared with standard care?
- For people with alcohol dependence, which medication is most likely to improve adherence and thereby promote abstinence and prevent relapse?

ADDITIONAL EDUCATIONAL RESOURCES

[All free access]

Public Health England Alcohol Learning Resources
www.alcohollearningcentre.org.uk/

Alcohol Identification and Brief Advice e-learning project
www.alcohollearningcentre.org.uk/eLearning/IBA

NICE Pathways
www.Pathways.nice.org.uk/pathways/alcohol-use-disorders

A comprehensive perspective on the global consumption of alcohol, patterns of drinking, health consequences and policy responses
www.who.int/substance_abuse/publications/global_alcohol_report/en/

A practical guide from the National Institute of Alcohol and Alcoholism in the USA
http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf

A detailed review of the causes and consequences of alcohol use disorders is found in chapter 2 of the NICE Clinical Practice Guideline 115 (www.nice.org.uk/CG115).

INFORMATION RESOURCES FOR PATIENTS

An interactive web-based programme to help people drink less
www.nhs.uk/Change4Life/Pages/drink-less-alcohol.aspx

Mutual aid organisations providing free meetings and support throughout the UK
www.alcoholics-anonymous.org.uk/
www.smartrecovery.org.uk/

Help to find an alcohol treatment service:
www.alcoholconcern.org.uk/concerned-about-alcohol/alcohol-services

Adfam, a charity aiming to improve support for families affected by drug and alcohol problems
www.adfam.org.uk/

Calculating units of alcohol

A drink's alcohol content is usually expressed by the standard measure 'Alcohol by Volume' or ABV. This is a measure of the amount of pure alcohol as a percentage of the total volume of liquid in a drink, and is found on the labels of cans and bottles. For example, if a can of beer has a label reading "5% ABV" or "alcohol volume 5%", this means that 5% of the volume of that drink is pure alcohol.

You can work out how many units there are in any drink by multiplying the total volume of a drink (in ml) by its ABV (which is measured as a percentage) and dividing the result by 1,000:

Number of units = Strength (ABV) x Volume (ml) ÷ 1,000

For example, to work out the number of units in a pint (568ml) of strong lager (ABV 5%):

Number of units = 5 (%) x 568 (ml) ÷ 1,000 = 2.84

This is worth doing, as the increasing strength of many alcoholic drinks and the larger glass sizes served in bars mean that people are often drinking more alcohol than they realise.

Units calculators are available e.g. http://www.nhs.uk/Tools/Pages/Alcohol-unit-calculator.aspx

BOX 1: Units of alcohol and how to calculate them

Category of Drinking	**Definition**	**AUDIT score**
Low risk	No amount of alcohol consumption can be called 'safe', but risks of harm are low if below levels	7 or less
Increasing risk ('hazardous')	Regularly drinking more than 2-3 units a day (women) and more than 3-4 units a day (men)	8-15
Higher risk ('harmful')	Regularly drinking more than 6 units per day (women) or more than 8 units per day (men) Or more than 35 units per week (women) and more than 50 units per week (men)	16-19
Dependence (as defined by the International Classification of Disorders (ICD-10) [11].	**A definite diagnosis of dependence should be made only if three or more of the following have been present together at the same time during the previous year:** (a) a strong desire or sense of compulsion to drink alcohol (b) difficulties in controlling drinking behaviour in terms of its onset, termination, or levels of consumption (c) a physiological withdrawal state when drinking has ceased or been reduced, as evidenced by: the characteristic alcohol withdrawal syndrome; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms e.g. benzodiazepines (d) evidence of tolerance, such that increased quantities of alcohol are required in order to achieve the effects originally produced by lesser amounts (e) progressive neglect of alternative pleasures or interests because of alcohol consumption, increased amount of time necessary to obtain or drink alcohol or to recover from its effects (f) persisting with drinking alcohol despite clear evidence of overtly harmful consequences, such as harm to the liver, depressive mood states, or impaired cognitive functioning It is an essential characteristic of the dependence syndrome that either alcohol consumption or a desire to drink alcohol is present; the subjective awareness of compulsion to drink alcohol is most commonly seen during attempts to stop or control substance use	20 or more

TABLE 1: A classification and definition of Alcohol Use Disorders

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)	
1. How often do you have a drink containing alcohol? (0) Never (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2. How many units of alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8 or 9 (4) 10 or more	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3. How often do you have 6 or more units if female, or 8 or more units of male, on a single occasion in the last year? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	10. Has a relative or friend, doctor or another health worker been concerned about your drinking or suggested that you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
	TOTAL SCORE:

TABLE 2: The Alcohol Use disorders Identification Test (AUDIT)

The rationale: A large body of international research evidence indicates that 1 in 8 people drinking at increasing risk or higher risk levels who receive structured brief advice will reduce their drinking to within lower risk levels [2]. Raising the issue of alcohol consumption with patients often meets with a number of different attitudes, including indifference, confusion about what is and isn't healthy, and possibly defensiveness and irritability. The clinician should ensure that they are aware of the facts about alcohol consumption and health-related harms in order to accurately convey the risks of drinking to the patient. It is important to avoid stigmatising terms like 'alcoholic', emphasising the concept of increasing risk with increasing consumption, and suggesting trying to cut down to a lower risk level rather than stopping. However, the clinician should also be able to detect alcohol dependence and refer on for specialist help.

Stage 1: Raise the issue

The most time and resource-effective strategy in non-specialist settings is to target those at greatest risk i.e. people with relevant physical (e.g. hypertension, gastrointestinal or liver problems) or mental health (anxiety or depression) conditions, at risk of self-harm, or who regularly experience accidents or minor trauma.

Ask the first three questions on the AUDIT questionnaire (table 2) and score the answers (known as AUDIT-C).

Score of 5+: suggests a high likelihood that the person is drinking at an increasing risk level, and the full AUDIT questionnaire should be administered.

Stage 2: Administer and score the 10-item AUDIT questionnaire

7 or less: this should be fed back in a positive manner e.g. re-iterate the sensible drinking guidelines and point out that people who exceed these levels increase their chances of alcohol-related health problems like accidents, injuries, high blood pressure, liver disease, cancer, and heart disease, whilst congratulating them for adhering to guidance.

8-19: this suggests that the patient's drinking pattern is in the increasing risk or higher risk band, and the clinician should move to offering brief advice as described in stage 3.

Stage 3: Deliver structured Brief Advice

Use an open-ended 'transitional' statement such as 'how important is it for you to change your drinking?', possibly accompanied by a simple 'readiness ruler' i.e. asking the patient to rate how confident they feel in making changes between 1 and 10. This can be followed by asking what would have to happen to make the number go up.

A structured episode of brief advice may only last 5-10 minutes, and is best guided by a Structured Advice Tool (such as the one available at http://www.alcohollearningcentre.org.uk/alcoholeLearning/learning/IBA/Module4_v2/pdf/structured_advice_tool.pdf)

This makes use of the FRAMES structure for brief interventions (Feedback, Responsibility, Advice, Menu, Empathy, Self-efficacy). The leaflet provides material to use for three of these elements:

- **Feedback** on the patient's level of drinking when compared to others, the common effects of drinking, and the potential benefits of reduction
- A **menu** of options to support the attainment of their preferred drinking goal
- **Advice** on units and limits

The clinician should aim to be firm enough to ensure that the patient realises that it is their

responsibility to make the change (restating the need to reduce risk and encouraging the patient to begin now), whilst also showing **empathy** (e.g. *'it can be very difficult to make these changes if everyone around you is drinking heavily'*) and aiming to boost their confidence and **self-efficacy** (*'You mentioned you were going to drink a non-alcoholic drink first when you get home in the evening. That sounds like an excellent start. Let's see how you get on and arrange another time to talk to discuss how you get on'*).

It is a good idea to offer a follow-up appointment to assess progress. An 'extended brief intervention' places greater emphasis on exploring the pros and cons of change and formulating a specific action plan. This approach is often based on the principles of motivational interviewing [29], and again is best guided by a structured leaflet such as the one available at: http://www.alcohollearningcentre.org.uk/alcoholeLearning/learning/IBA/Module5_v2/extended_intervention_worksheet.pdf

A patient should be referred for more specialist alcohol assessment and intervention if they ask for such help, are already exhibit significant alcohol-related harm, have an AUDIT score of more than 20, or exhibit the features of the dependence syndrome.

A step-by-step teaching module and full range of materials is available at www.alcohollearningcentre.org.uk/eLearning/

BOX 2: Delivering alcohol Identification and Brief Advice (IBA) in Practice

Daily alcohol consumption	**15-25 units**		**30-49 units**		**50-60 units**
Severity of alcohol dependence	**Moderate SADQ score 15-25**		**Severe SADQ score 30-40**		**Very severe SADQ score 40-60**
Day 1 (starting dose)	15mg four times/day	25mg four times/day	30mg four times/day	40mg four times/day[a]	50mg four times/day[b]
Day 2	10mg four times/day	20mg four times/day	25mg four times/day	35mg four times/day[a]	45mg four times/day[b]
Day 3	10mg three times/day	15mg four times/day	20mg four times/day	30mg four times/day	40mg four times/day[a]
Day 4	5mg three times/day	10mg four times/day	15mg four times/day	25mg four times/day	35mg four times/day[a]
Day 5	5mg twice/day	10mg three times/day	10mg four times/day	20mg four times/day	30mg four times/day
Day 6	5mg at night	5mg three times/day	10mg three times/day	15mg four times/day	25mg four times/day
Day 7		5mg twice/day	5mg three times/day	10mg four times/day	20mg four times/day
Day 8		5mg at night	5mg twice/day	10mg three times/day	15mg four times/day
Day 9			5mg at night	5mg three times/day	10mg four times/day
Day 10				5mg twice/day	10mg three times/day
Day 11				5mg at night	5mg three times/day
Day 12					5mg twice/day
Day 13					5mg at night

SADQ = Severity of Alcohol Dependence Questionnaire. A copy can be found at http://www.alcohollearningcentre.org.uk/Topics/Latest/Resource/?cid=4615

[a] Doses of chlordiazepoxide in excess of 30mg four times/day should be prescribed only in severe alcohol dependence and the response to treatment should be monitored regularly and closely

[b] Doses of chlordiazepoxide in excess of 40mg four times/day should be prescribed only in very severe alcohol dependence. Such doses are rarely necessary in women and children and never in older people or in cases of liver impairment.

TABLE 3: Suggested titrated fixed-dose chlordiazepoxide protocol for treatment of alcohol withdrawal (from [1] p191)

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